

INVOICE

Occupational Therapy Services

Invoice #: _____

Date: _____

PROVIDER:

NPI #: _____

Phone: _____

PATIENT / BILL TO:

DOB: _____

ID #: _____

Date of Service	CPT Code / Description	Units/Hours	Rate	Total
	Initial Evaluation (97165-97167)			
	Therapeutic Exercise (97110)			
	Self-Care/Home Mgmt (97535)			
	Cognitive Intervention (97129)			

Subtotal: \$ _____

Adjustments: \$ _____

Balance Due: \$ _____

Clinical Notes / Recommendations:

Please make checks payable to: _____

Terms: Payment is due within 15 days of invoice date.

Thank you for allowing us to assist in your health and independence.